Important

Please read this page carefully before signing the application on the reverse side.

1. Release of information

By enrolling in Fallon Senior Plan,™ I authorize the Centers for Medicare and Medicaid Services (CMS) to provide information to Fallon Community Health Plan confirming my entitlement to Medicare Hospital Insurance Benefits (Part A) and to Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I also authorize Fallon Senior Plan's™ providers or any other holder of medical or other relevant information about me to release to CMS or CMS' agents the information needed to administer Title XVIII of the Social Security Act. _____ Initials

2. Lock-in

I understand that, beginning on the date my Fallon Senior Plan™ coverage is effective, I must receive all of my health care from Fallon Senior Plan™ providers, with the exception of emergency or urgently needed services, or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by Fallon Senior Plan™ and other services contained in my Fallon Senior Plan™ *Member Handbook/Evidence of Coverage* (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization from FCHP, NEITHER MEDICARE NOR FALLON SENIOR PLAN™ WILL PAY FOR THE SERVICES. _____ Initials

3. I understand that while the "effective date of coverage" of this form is when I should begin using Fallon Senior Plan's™ services, the plan will still be sending me final approval of my enrollment in Fallon Senior Plan.™ I understand that I should not disenroll from any Medicare supplement plan or Medigap/Medicare Select plan until I receive that confirmation from Fallon Senior Plan.™ _____ Initials

4. I understand I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums, if applicable. _____ Initials

5. I understand that I can be a member of only one Medicare + Choice plan at a time. By enrolling in Fallon Senior Plan on this form, I will automatically be disenrolled from any other Medicare + Choice plan of which I am currently a member. _____ Initials

6. I also understand that since I can be a member of only one Medicare + Choice plan at a time, I cannot enroll in more than one Medicare + Choice plan with the same effective date of coverage. If I do this, my enrollments will be cancelled and I will have to fill out a new enrollment form to become a member of a Medicare + Choice plan. _____ Initials

7. I understand that I may disenroll from Fallon Senior Plan™ by sending a written request to Fallon Community Health Plan, the Social Security Office or the Railroad Retirement Board. Until the effective date of disenrollment, I must continue to receive all routine health care services from Fallon Senior Plan™ providers. _____ Initials

8. I understand that as a member of Fallon Senior Plan,™ I have the right, if I disagree, to appeal service and payment denials made by the plan. _____ Initials

9. I understand that it is my responsibility to inform Fallon Senior Plan™ before permanently moving out of the service area. I understand that if I move permanently out of the service area, Fallon Senior Plan™ is required to disenroll me. _____ Initials

10. Please fill in the blanks in the "Health Insurance" section on the reverse side with the information on your Medicare card. This information must be filled out, or you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board. **We cannot consider this enrollment form complete until we have obtained this information.** _____ Initials

11. If the beneficiary is unable to sign, a court-appointed Legal Guardian or person having Durable Power of Attorney for Health Care (DPAHC) or designated in a written advance directive, if authorized by state law, must sign the following line. A copy of the proof of Legal Guardian, DPAHC, written advance directive or proof of authorization by state law must be attached. _____ Initials

Questions? Call Fallon Customer Service at 1-800-868-5200; (TDD/TTY: 1-800-608-7677).
www.fchp.org

FALLON USE ONLY

Remarks:

Effective date of coverage: _____
Place of enrollment: _____
Rep's initials: _____
FCHP identification #: _____
M.D. code: _____
Location code: _____

Non-group #: _____
Group name: _____
Date received: _____
Medical record #: _____
CMS Plan #: H9001
❑ New enrollment ❑ Age-in

Sales Exec. Initials ____

Fallon Senior Plan™ Retiree Group Enrollment Form

PERSONAL INFORMATION

Last name	First name	Initial	Sex	DOB / /	Home phone # (_____) _____
Permanent residence address	City/Town	State	Zip	County	
Mailing address if different from above	Primary language	Social Security #			

ADDITIONAL INFORMATION

Social Security Act
Please read item 10 on the reverse before completing.

MEDICARE HEALTH INSURANCE

Name of beneficiary _____

Medicare claim number __ __ __ - __ __ - __ __ __ __ - __

Is entitled to:	**Effective date**
Hospital Insurance (Part A)	_____ _____ _____
Medical Insurance (Part B)	_____ _____ _____

Name of chosen primary care physician (PCP)
_____

Your requested Fallon Senior Plan™ Membership Effective Date: _____/ _____ / _____

If you are an existing patient, check here. ❒

1. Do you have End Stage Renal Disease (ESRD)? Yes ❒ No ❒
Special rules apply if you have or develop End Stage Renal Disease. Please call the plan for more information.
2. Are you currently a resident in an institution?* Yes ❒ No ❒
   If yes, name of institution: _____ Date of admission: _____
   Phone number of institution: _____
3. Do you receive Medicaid benefits?* Yes ❒ No ❒
4. Do you, either on your own or through your spouse, have any health coverage other than Medicare, such as private insurance, Worker's Compensation or VA benefits? Yes ❒ No ❒
   If yes, what kind of coverage do you have? _____ Name of provider: _____
5. Do you or your spouse currently work? Yes ❒ No ❒

*Note: Your answer to this question will not affect your eligibility to enroll in Fallon Senior Plan.™

Consent

I authorize anyone who provides medical services to me to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, disease management programs, quality management, coordination of care, health services management, accreditation and processing and payment of related claims.

I understand that my signature on this application certifies that I have read and understand the contents of this application. Please refer to Fallon Senior Plan™ *Member Handbook/Evidence of Coverage* document for a written copy of the rules you must follow in order to receive coverage under Fallon Senior Plan.™ **Please read item 11 on reverse side before signing.**

X _____ _____ _____ _____ _____

Applicant or legal guardian signature (if applicable). Documentation required. Please see item 11 on the reverse.	Date	Individual assisting (if applicable) in completion of this application	Relationship	Date

Employer company name _____ Employer company signature _____